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Recommendations and Reports

MORBIDITY AND MORTALITY WEEKLY REPORT

Guidelines for Preventing the Transmission of *Mycobacterium tuberculosis* in Health-Care Facilities, 1994

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FIGURE 1. Protocol for conducting a tuberculosis (TB) risk assessment in a health-care facility

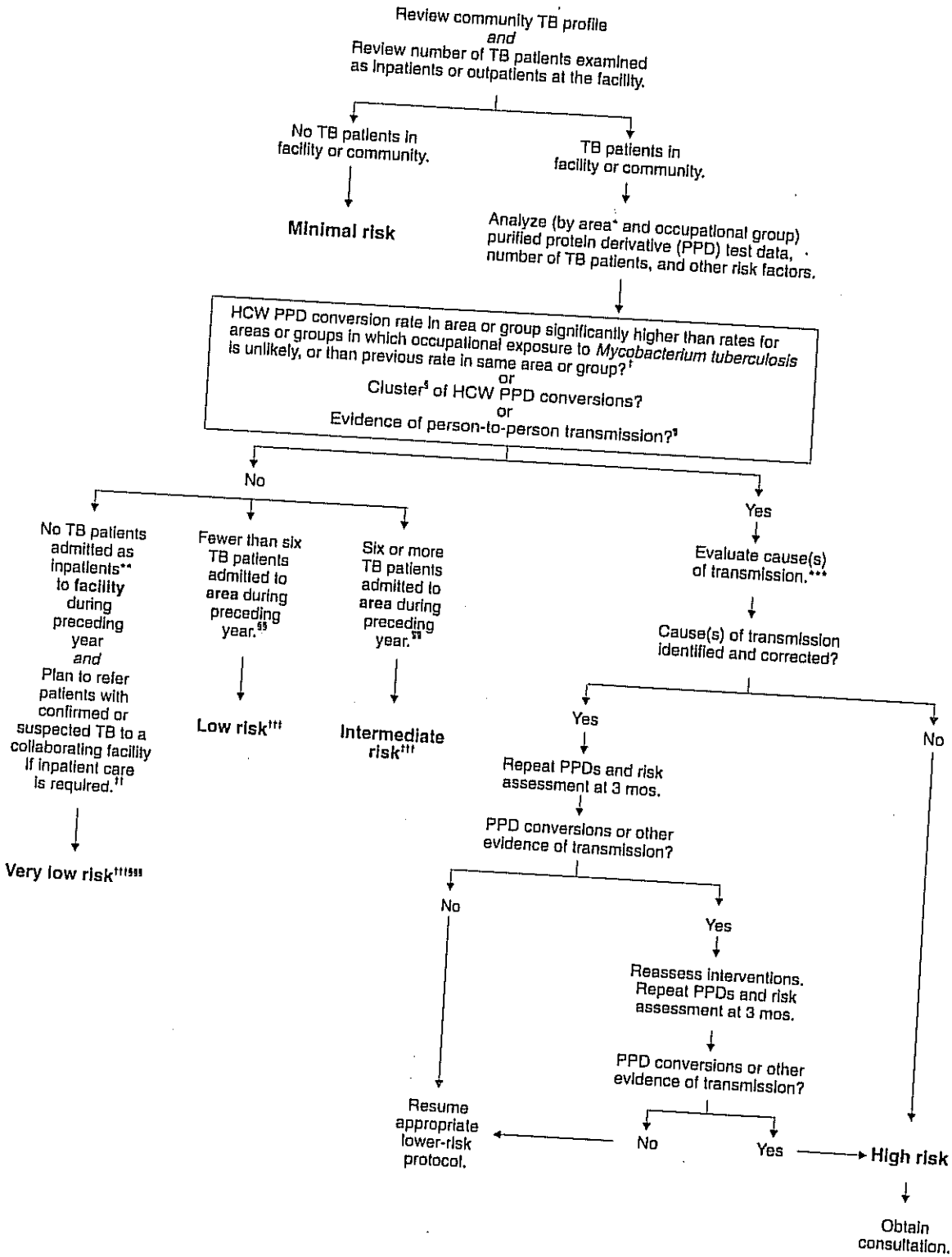

FIGURE 1. Protocol for conducting a TB risk assessment in a health-care facility — Continued

*Area: a structural unit (e.g., a hospital ward or laboratory) or functional unit (e.g., an internal medicine service) in which HCWs provide services to and share air with a specific patient population or work with clinical specimens that may contain viable *M. tuberculosis* organisms. The risk for exposure to *M. tuberculosis* in a given area depends on the prevalence of TB in the population served and the characteristics of the environment.

†With epidemiologic evaluation suggestive of occupational (nosocomial) transmission (see Problem Evaluation section in the text).

§Cluster: two or more PPD skin-test conversions occurring within a 3-month period among HCWs in a specific area or occupational group, and epidemiologic evidence suggests occupational (nosocomial) transmission.

¶For example, clusters of *M. tuberculosis* isolates with identical DNA fingerprint (RFLP) patterns or drug-resistance patterns, with epidemiologic evaluation suggestive of nosocomial transmission (see Problem Evaluation section in the text).

**Does not include patients identified in triage system and referred to a collaborating facility or patients being managed in outpatient areas.

††To prevent inappropriate management and potential loss to follow-up of patients identified in the triage system of a very low-risk facility as having suspected TB, an agreement should exist for referral between the referring and receiving facilities.

§§Or, for occupational groups, exposure to fewer than six TB patients for HCWs in the particular occupational group during the preceding year.

¶¶Or, for occupational groups, exposure to six or more TB patients for HCWs in the particular occupational group during the preceding year.

***See Problem Evaluation section in the text.

†††Occurrence of drug-resistant TB in the facility or community, or a relatively high prevalence of HIV infection among patients or HCWs in the area, may warrant a higher risk rating.

§§§For outpatient facilities, if TB cases have been documented in the community but no TB patients have been examined in the outpatient area during the preceding year, the area can be designated as very low risk.

care or where cough-inducing procedures are performed). This should include both inpatient and outpatient areas. In addition, risk assessments should be conducted for groups of HCWs who work throughout the facility rather than in a specific area (e.g., respiratory therapists; bronchoscopists; environmental services, dietary, and maintenance personnel; and students, interns, residents, and fellows).

- Classification of risk for a facility, for a specific area, and for a specific occupational group should be based on a) the profile of TB in the community; b) the number of infectious TB patients admitted to the area or ward, or the estimated number of infectious TB patients to whom HCWs in an occupational group may be exposed; and c) the results of analysis of HCW PPD test conversions (where applicable) and possible person-to-person transmission of *M. tuberculosis* (Figure 1).
- All TB infection-control programs should include periodic reassessments of risk. The frequency of repeat risk assessments should be based on the results of the most recent risk assessment (Table 2, Figure 1).
- The "minimal-risk" category applies only to an entire facility. A "minimal-risk" facility does not admit TB patients to inpatient or outpatient areas and is not located in a community with TB (i.e.,